CURRENT PATIENT-SAME PROBLEM UPDATE

Name________________________
Date________________________
Part of Body________________________

SINCE YOUR LAST VISIT:

Do you feel the problem is getting ☐Worse ☐Better ☐Staying the same?

Have you missed any work because of the problem? ☐No ☐Yes, how much?____________

List/describe all treatments that you have had so far for the problem you are seeing the orthopaedic doctor today:
(For example, non-prescription or prescription medicines (which ones?), physical therapy, injections, chiropractic/manipulation, etc.)

Allergies to Medicines: Circle here if NONE

Medicine	Reaction

List Medications you are taking **(or ATTACH LIST):** Circle here if NONE

Drug	Dose	Frequency (How many times a day? Or How often?)

Past Medical History: Do **YOU** currently have or had in the past any of the following conditions? Circle all that apply

NONE APPLY

Diabetes
Heart problems
-Heart attack
-Heart failure
-Angioplasty
-Heart vessel stent
-Abnormal heart beat
High blood pressure
High cholesterol
Lung disease
Tuberculosis
Asthma
Bronchitis

Emphysema
Liver disease
Stomach ulcers
Acid Reflux
Thyroid disease
Stroke
Seizures
Alcoholism
Cancer
-What kind?__________
Kidney failure
-On dialysis
Kidney stones

Osteoporosis
Osteoarthritis (old age or wear and tear arthritis)
Rheumatoid arthritis (blood test positive arthritis)
Bleeding disorders
Anemia
Blood clots in legs (took or taking blood thinner for)
Blood clots in lung
Anxiety
Depression

Seen a psychiatrist
HIV
Hepatitis
Sleep apnea
-Use C-PAP machine
MRSA infection

Other:__________

____

____

Past Surgical History: Circle any area of the body you have had surgery on

NONE APPLY

Spine-neck
Spine-lower back
Brain
Heart
Lung
Gallbladder
Stomach/Intestine
Appendix

Hernia
Colon
Rectum
Hemorrhoids
Hysterectomy
C-section
Kidneys
bladder/ urinary tract

Prostate
Shoulders
Arms
Hands
Hips
Knees
Legs
Feet

Eyes
Ears
Nose
Throat/ tonsils
Other:

____

Family History: Does or did any **blood relative** have any of the following conditions. Circle all that apply

NONE APPLY

Arthritis
Heart disease
High blood pressure

Diabetes
Cancer
Bleeding disorders

Mental illness
Alcoholism
Kidney disease

Other:__________

____

Social History: Please answer each of the following 7 questions.

1. Current marital status:
   - ☐Single
   - ☐Married
   - ☐Cohabitating
   - ☐Divorced
   - ☐Widowed

2. Current work status:
   - ☐Working. ☐Full duty ☐Light duty
   - Occupation: ____________________
   - ☐Disabled, since ____________________
   - ☐Retired
   - ☐Unemployed
   - ☐Student
   - ☐Homemaker

3. Tobacco use:
   - ☐Never
   - ☐Smoking __________pack(s)/day
   - ☐Quit smoking in __________(year)
   - ☐Cigars
   - ☐Chewing tobacco
   - ☐Nicotine patch/ gum

4. Alcohol use:
   - ☐Never
   - ☐Rarely (less than once per month)
   - ☐Occasionally (less than twice per week)
   - ☐Frequently (more than twice per week)
   - ☐Recovering alcoholic

5. Drug abuse:
   - ☐Never
   - ☐In the past
   - ☐Current

6. Number of children: __________

7. I live:
   - ☐Alone
   - ☐With:____________________

Review of Systems: Do **YOU currently** have any of the following? Circle all that apply

NONE APPLY

CONSTITUTIONAL
- Unexplained wt loss
- Recent fevers or chills (past 1 or 2 weeks)
- Recent night sweats

EYES
- Glasses or contact lens
- Recent change of vision

EAR, NOSE, MOUTH, THROAT
- Difficulty swallowing
- Hoarseness
- Loss of hearing
- Ear pain
- Nosebleeds
- Gum trouble

CARDIOVASCULAR
- Heart or chest pain
- Abnormal heartbeat

LUNG
- Morning cough
- Shortness of breath
- Productive cough or sputum
- Sleep Apnea
- Use C-PAP machine

DIGESTIVE
- Heartburn
- Nausea or vomiting
- Stomach pain or ulcers
- Frequent diarrhea
- Frequent constipation
- Hemorrhoids

URINARY
- Burning on urination
- Difficulty starting urination
- Incontinence
- Urinate at night more than once

NEUROLOGICAL
- Stroke
- Seizures
- Blackouts
- Headaches/ migraines
- Paralysis

MUCULOSKELETAL
- Osteoporosis
- Chronic joint pains
- Chronic low back pain
- Chronic neck pain

SKIN
- Frequent rashes
- Frequent itchiness
- Easy bruising
- Swollen ankles

ENDOCRINE
- Diabetes
- Take insulin

PSYCHIATRIC
- Depression
- Nervous exhaustion
- Anxiety
- Paranoia
- Obsessive compulsive disorder
- Schizophrenia
- Bulimia
- Anorexia

HEME/LYMPHATIC
- Anemia
- Chronic swollen legs

ALLERGIC/IMMUNE
- Environmental allergens
- Seasonal allergies
- Asthma

HAVE YOU EVER HAD A BONE DENSITY SCAN (DEXA SCAN)? YES☐ NO☐ IF YES, WHEN________

Patient's Signature______________________________ **Date**____________________

Physician's Signature______________________________ **Date**____________________